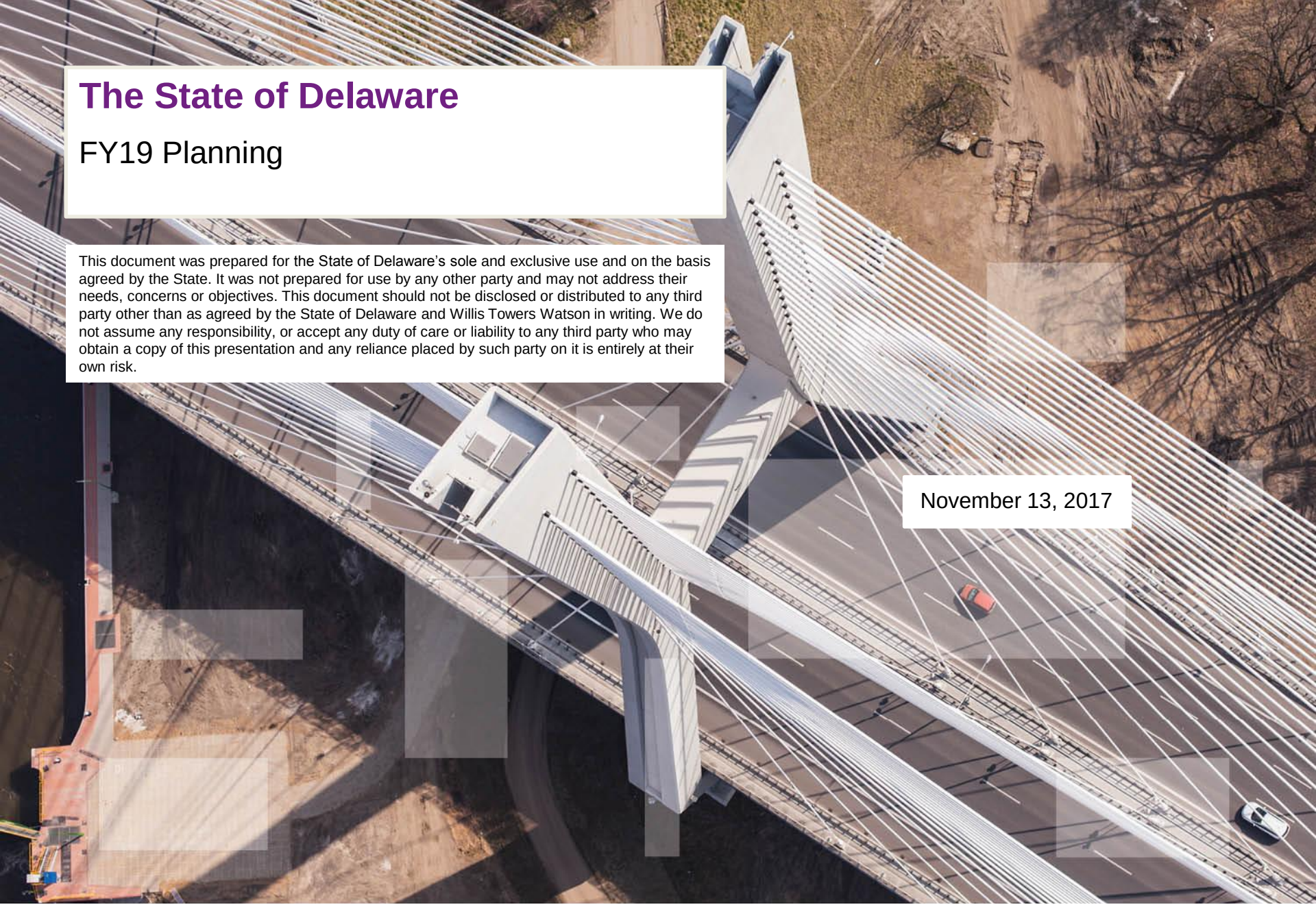

The State of Delaware

FY19 Planning

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November 13, 2017

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- FY19 Planning
- Next Steps

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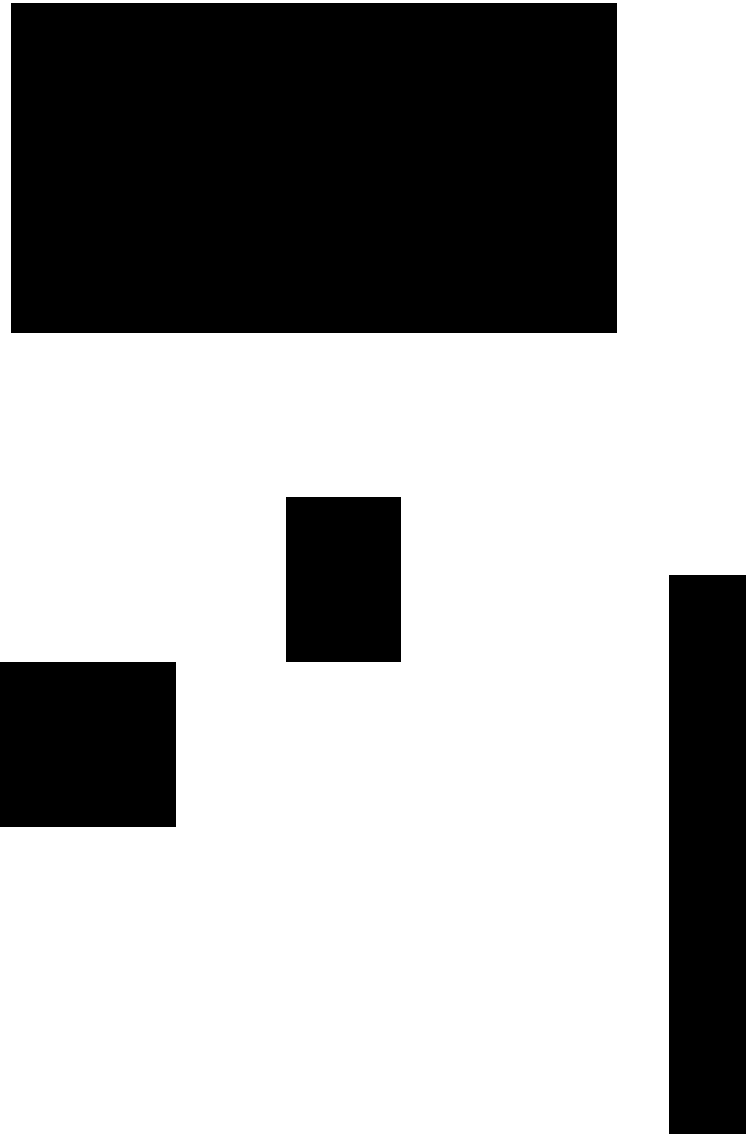
Refocusing on the Long Term Plan



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GHIP long term health care cost projections

- As discussed in the September 25, 2017 SEBC meeting, GHIP Fund Equity balance as of 6/30/2017 is $102.7m with $25m surplus, projected to increase to $36m by end of FY18
- Current GHIP surplus will be eroded if revenue growth (i.e., increases to premium contributions) does not keep pace with expected increases in health care expenditures
- The “no change” long term health care cost projections on the following page has been updated to reflect the potential impact of the ACA excise tax (“Cadillac” tax)
  - Despite efforts to repeal, excise tax is still slated to take effect in 2020, with regulatory guidance pending
  - Absent program changes, GHIP excise tax liability projected to be $0.2m in the second half of FY20 and $4.0m in FY21 assuming 6% annual health care trend
    - Assumes excise tax calculated based on expected plan expenditures and not premium equivalent rates
- Implementing changes for 7/1/2018, along with 2% annual premium contributions increases, will delay the erosion of the GHIP surplus
  - Site-of-care steerage for basic imaging, high tech imaging, and outpatient lab
  - Orthopedic and spine COEs

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GHIP long term health care cost projections

No Program Changes

GHIP Costs ($ millions)	FY17 Actual	FY18 Projected	FY19 Projected	FY20 Projected	FY21 Projected	FY22 Projected	FY23 Projected
GHIP Revenue							
Premium Contributions (No Change)[1]	$799.0	$810.3	$810.3	$810.3	$810.3	$810.3	$810.3
Other Revenues[2]	$81.6	$85.1	$87.3	$91.7	$96.3	$101.1	$106.2
Total Operating Revenues	**$880.6**	**$895.4**	**$897.6**	**$902.0**	**$906.6**	**$911.4**	**$916.5**
GHIP Expenses (Claims/Fees)							
Operating Expenses (No Change)[3]	$816.8	$881.5	$937.5	$984.5	$1,032.7	$1,084.3	$1,137.5
Excise Tax Liability[4]	-	-	-	*$0.2*	*$4.0*	*$9.1*	*$16.3*
Adjusted Net Income (Revenue less Expense/Excise Tax)	**$63.8**	**$13.9**	**($39.9)**	**($82.7)**	**($130.1)**	**($182.0)**	**($237.3)**
Balance Forward	$38.9	$102.7	$116.6	$76.7	($6.0)	($136.1)	($318.1)
Ending Balance	$102.7	$116.6	$76.7	($6.0)	($136.1)	($318.1)	($555.4)
- Less Claims Liability[5]	*$54.0*	*$56.5*	*$60.1*	*$63.1*	*$66.2*	*$69.5*	*$72.9*
- Less Minimum Reserve[5]	*$24.0*	*$24.0*	*$25.5*	*$26.8*	*$28.1*	*$29.5*	*$30.9*
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$36.1**	**($8.9)**	**($95.9)**	**($230.4)**	**($417.1)**	**($659.2)**

Note: FY17 Actual based on final June 2017 Fund Equity report and FY18 Projected based on final approved budget as of 8/26/2017 and FY18 elections as of June 2017.

[1] Includes State and employee/pensioner premium contributions and assumes no increase to premiums 7/1/2017 and beyond.

[2] Includes Rx rebates, EGWP payments, participating group fees, and other revenues.

[3] FY19 expenses based on 24-months of claims experience through June 2017, preliminary trend assumptions, year 2 ESI contract savings, and savings from initiatives adopted 7/1/2017. FY20-FY23 projected assuming 5% annual increase over FY19 (6% health care trend less 1% reduction).

[4] 40% excise tax on the value of employer sponsored health care coverage over specified thresholds starting CY 2020. Threshold assumed to increase at 2% annually

[5] Claims Liability and Minimum Reserve levels shown to increase with overall GHIP expense growth for FY19-FY23.

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GHIP long term health care cost projections

With Program Changes

GHIP Costs ($ millions)	FY17 Actual	FY18 Projected	FY19 Projected	FY20 Projected	FY21 Projected	FY22 Projected	FY23 Projected
GHIP Revenue							
Premium Contributions (No Change)[1]	$799.0	$810.3	$810.3	$810.3	$810.3	$810.3	$810.3
Other Revenues[2]	$81.6	$85.1	$87.3	$91.7	$96.3	$101.1	$106.2
7/1 Rate Action (2019-2023 + 2% annual premium increase)[3]	-	-	*$16.2*	*$32.4*	*$48.6*	*$64.8*	*$81.0*
Total Operating Revenues	**$880.6**	**$895.4**	**$913.8**	**$934.4**	**$955.2**	**$976.2**	**$997.5**
GHIP Expenses (Claims/Fees)							
Operating Expenses (No Change)[4]	$816.8	$881.5	$937.5	$984.5	$1,032.7	$1,084.3	$1,137.5
Recommended Opportunities[5]			*($3.5)*	*($6.4)*	*($8.8)*	*($10.7)*	*($12.6)*
Excise Tax Liability[6]	-	-	-	*$0.2*	*$4.0*	*$9.1*	*$16.3*
Adjusted Net Income (Revenue less Expense/Excise Tax)	**$63.8**	**$13.9**	**($20.2)**	**($43.9)**	**($72.7)**	**($106.5)**	**($143.7)**
Balance Forward	$38.9	$102.7	$116.6	$96.4	$52.5	($20.2)	($126.7)
Ending Balance	$102.7	$116.6	$96.4	$52.5	($20.2)	($126.7)	($270.4)
- Less Claims Liability[7]	$54.0	$56.5	$59.9	$62.7	$65.6	$68.8	$72.1
- Less Minimum Reserve[7]	$24.0	$24.0	$25.4	$26.6	$27.8	$29.2	$30.6
GHIP Surplus (After Reserves/Deposits)	**$24.7**	**$36.1**	**$11.1**	**($36.8)**	**($113.6)**	**($224.7)**	**($373.1)**

Note: FY17 Actual based on final June 2017 Fund Equity report and FY18 Projected based on final approved budget as of 8/26/2017 and FY18 elections as of June 2017.

[1] Includes State and employee/pensioner premium contributions.

[2] Includes Rx rebates, EGWP payments, participating group fees, and other revenues.

[3] Includes State and employee/pensioner premium contributions and assumes premiums increase by 2% annual for FY19-FY23.

[4] FY19 expenses based on 24-months of claims experience through June 2017, preliminary trend assumptions, year 2 ESI contract savings, and savings from initiatives adopted 7/1/2017. FY20-FY23 projected assuming 5% annual increase over FY19 (6% health care trend less 1% reduction).

[5] Reflects 7/1/2018 implementation of site of care steerage Option 1 and ortho/spine COE with three-year phase in of 75% coinsurance design for non-COEs.

[6] 40% excise tax on the value of employer sponsored health care coverage over specified thresholds starting CY 2020. Threshold assumed to increase at 2% annually

[7] Claims Liability and Minimum Reserve levels shown to increase with overall GHIP expense growth for FY19-FY23.

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Opportunities under consideration for FY19

- From our last meeting, the SEBC expressed interest in continuing to discuss the following opportunities under consideration for FY19:
  - Site-of-care steerage
  - Centers of Excellence
  - Active benefits enrollment

- The following topics will be tabled for a future SEBC meeting:
  - Cost transparency tools
  - Tobacco surcharges
  - HSA plan implementation
  - Plan design changes for current plans

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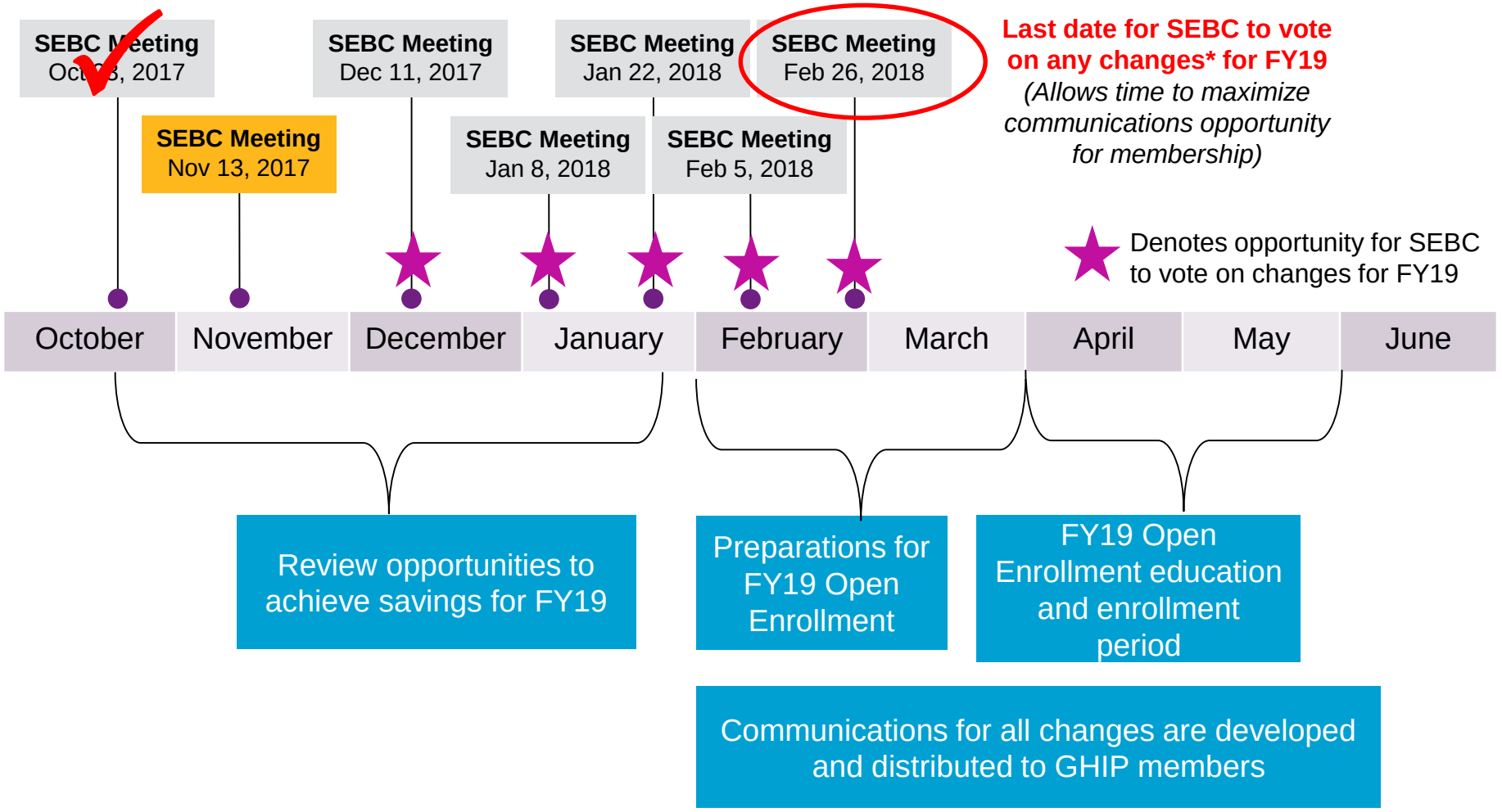
Focal points for the SEBC – planning for FY19



*To maximize the success of rolling out a HSA plan, the State should consider implementation for a January 1 effective date, which has other timing considerations that are discussed in further detail later in this document.

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FY19 Planning

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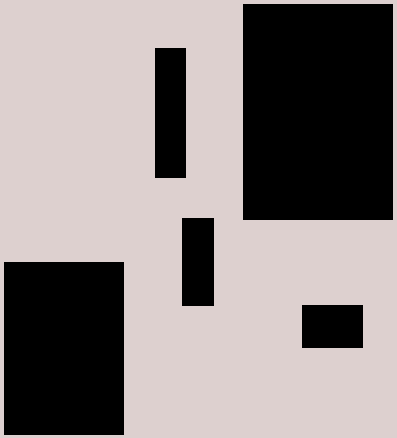
Site-of-Care Steerage



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Site-of-care steerage

Prior savings assumptions and actual utilization changes – urgent care

- Per request from the SEBC, the below exhibit outlines the assumptions and savings estimates that were considered in the decision to implement site-of-care steerage for urgent care

Service	Plan Design (in-network only)		Original Assumptions[1]	
	FY2016 (through 6/30/16)	FY2017 (effective 7/1/16)	Change in utilization required to "break even"	Estimated annual savings[2]
Urgent care	$25/$30 copay (HMO/PPO)	$15/$20 copay (HMO/PPO)	200 visits redirected from ER to urgent care Offsets $300k cost increase from copay reduction with no behavior change	Savings of $1,434 per visit if > 200 visits are redirected **= >$290k**
Emergency room	$150 copay	$150 copay		

Service	Actual Change from FY16 to FY17 Increase / (Decrease)		
	Visits	Total Cost	Net Paid GHIP (after copay)
Urgent care	6,193	$861,000	$989,000
Emergency room	(569)	($926,000)	($586,000)
Total	5,624	($65,000)	$402,000

- Actual movement exceeded target (200 visits), with 569 fewer visits to emergency rooms
- Increase in urgent care center utilization (6,193 more visits) may be partially due to some members receiving services at an urgent care center rather than their primary care provider
- While the net GHIP cost increased, the important data point to focus on is the reduction in cost per visit- meaning there was a demonstrable steerage from ER to Urgent care setting

[1] From "FY17 Group Health Program Planning" document, reviewed at the March 18, 2016 SEBC meeting. http://ben.omb.delaware.gov/sebc/documents/2016/0318-planning.pdf
[2] Savings estimates reflect the difference in gross cost (i.e., before member cost-sharing).
[3] Source: Truven, November 2017. Includes active employees, early retirees and their families. Net Payment and Allowed Amount are computed using a completion factor for claims incurred but not reported.

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Site-of-care steerage

Prior savings assumptions and actual utilization changes – high tech imaging

- Per request from the SEBC, the below exhibit outlines the assumptions and savings estimates that were considered in the decision to implement site-of-care steerage for high tech imaging services

High tech imaging	Plan Design (in-network only)		Original Assumptions[1]	
	FY2016 (through 6/30/16)	FY2017 (effective 7/1/16)	Change in utilization required to "break even"	Estimated annual savings[2]
Freestanding facility	$15/20 copay (HMO/PPO)	$0 copay (HMO/PPO)	300 visits for these services redirected from hospital-based to freestanding facilities Offsets $233k cost increase from copay reduction with no behavior change	Savings of $800 per visit if > 300 visits are redirected **= >$240k**
Hospital-based facility	$15 copay	$35 copay		

High tech imaging	Actual Change from FY16 to FY17 Increase / (Decrease)		
	Visits	Total Cost	Net Paid GHIP (after copay)
Freestanding facility	111	$179,000	($3,000)
Hospital-based facility	(1,952)	($2,918,000)	($2,998,000)
Total	(1,841)	($2,739,000)	($3,001,000)

- Actual movement exceeded target (300 visits), with 1,952 fewer visits to hospital-based facilities
- High tech imaging spend (net paid after member copay) decreased by $3 million
- Average combined costs for imaging visits decreased by $62 per visit in total negotiated allowed cost and by $53 per visit in net payments (after member copay)

[1] From "FY17 Group Health Program Planning" document, reviewed at the March 18, 2016 SEBC meeting. http://ben.omb.delaware.gov/sebc/documents/2016/0318-planning.pdf
[2] Savings estimates reflect the difference in gross cost (i.e., before member cost-sharing).
[3] Source: Truven, November 2017. Includes active employees, early retirees and their families. Net Payment and Allowed Amount are computed using a completion factor for claims incurred but not reported.

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Site-of-care steerage

Revised design alternatives – Imaging and outpatient lab services

- The SEBC has expressed preference for the following plan design options, from among the iterations were modeled by Aetna and Highmark, for the Comprehensive PPO and HMO plans:

Service	Current	Presented at 10/23 SEBC Meeting		New "Hybrid" Option
		Preliminary Design 1[1]	Design 2	Design 1a
Basic Imaging				
▪ Freestanding Facility (preferred)	▪ $20 copay	▪ $0 copay	▪ $10 copay	▪ $0 copay
▪ Hospital-based Facility	▪ $20 copay	▪ $35 copay	▪ $45 copay	▪ $35 copay
High Tech Imaging				
▪ Freestanding Facility (preferred)	▪ $0 copay	▪ $0 copay	▪ $10 copay	▪ $10 copay
▪ Hospital-based Facility	▪ $35 copay	▪ $50 copay	▪ $60 copay	▪ $50 copay
Outpatient Lab				
▪ Preferred Lab	▪ $10 copay	▪ $10 copay	▪ $10 copay	▪ $10 copay
▪ Other Lab	▪ $10 copay	▪ $20 copay	▪ $25 copay	▪ $20 copay

- WTW recommends preliminary Design 1 for the following reasons:
  - Consistent with existing design for high tech imaging, which has been working well
  - Members who utilize the preferred site-of-care for imaging and lab services will not pay higher copays than they would currently, and will in fact pay less for basic imaging services

[1] Preliminary design presented during 8/21 SEBC meeting

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Site-of-care steerage

Estimated savings summary – best estimate

Carrier	Modeled Designs	Annual Claim Savings (%)[2]	Annual Claim Savings ($)	Annual Claim Savings General Fund ($)
Aetna	Preliminary Design 1[1]	0.35%	$0.5m	$0.3m
Highmark		0.20%	$0.8m	$0.5m
		Total Saving Opportunity – Design 1:	**$1.3m**	**$0.8m**
Aetna	Design 2	0.48%	$0.7m	$0.5m
Highmark		0.33%	$1.3m	$0.8m
		Total Savings Opportunity – Design 2:	**$2.0m**	**$1.3m**
Aetna	"Hybrid" Design 1a	0.38%	$0.6m	$0.4m
Highmark		0.20%	$0.8m	$0.5m
		Total Savings Opportunity – Design 1a:	**$1.4m**	**$0.9m**

- The design options modeled above assume design changes are adopted to promote site-of-care steerage for basic imaging services, high-tech imaging services and outpatient lab services
  - Consistent with existing site-of-care steerage design, modeling assumes that these changes would only apply to the Comprehensive PPO and the HMO plans
  - CDH Gold and First State Basic plans already have member cost differential built into design (via coinsurance for most plan provisions) to incentivize utilization of lower cost providers
  - Reflects the following steerage assumptions: approximately 33% of all members with high-tech imaging claims and 25% of basic imaging claims will be incurred at a freestanding facility; 25% of members with outpatient lab visits will be redirected to a preferred lab[3]
- Member disruption will vary based on procedure, education and specific provider

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels.
Savings for active and pre-65 retiree populations only; based on each vendor's best estimate of the expected utilization at the desired site of care.
[1] Preliminary design presented during 8/21 SEBC meeting; rounding may cause some numbers to vary slightly from original document.
[2] Savings largely attributable to copay differential rather than changes in member behavior.
[3] Preferred lab for Aetna: currently Quest, and adding Labcorp effective 1/1/18; for Highmark: Quest and Labcorp. NOTE: Related to the Lab steerage for the Aetna population, Labcorp pricing is 2% higher in aggregate than Quest. Savings may change slightly (overstated) to the extent members utilize Labcorp over Quest facilities.

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Site-of-care steerage

Estimated savings summary – maximum opportunity

Carrier	Modeled Designs	Annual Claim Savings (%)	Annual Claim Savings ($)	Annual Claim Savings General Fund ($)
Aetna[1]	Preliminary Design 1[3]	0.89%	$1.4m	$0.9m
Highmark[2]		1.76%	$6.8m	$4.3m
Total Saving Opportunity – Design 1:			**$8.2m**	**$5.2m**
Aetna[1]	Design 2	1.20%	$1.8m	$1.2m
Highmark[2]		1.89%	$7.3m	$4.7m
Total Savings Opportunity – Design 2:			**$9.1m**	**$5.9m**
Aetna[1]	"Hybrid" Design 1a	0.91%	$1.4m	$0.9m
Highmark[2]		1.76%	$6.8m	$4.3m
Total Savings Opportunity – Design 1a:			**$8.2m**	**$5.2m**

- For illustrative purposes only, the design options modeled above reflect the maximum site-of-care steerage savings opportunity for basic and high-tech imaging and outpatient lab services
  - Intended to highlight the range of achievable savings based on more effective steerage through copay differential and behavior change
  - Reflects aggressive but achievable steerage assumptions: approximately 50% of all members with high-tech imaging claims and 75% of basic imaging claims will be incurred at a freestanding facility; outpatient lab steerage varies by type of lab

General Fund split based on GHIP enrollment distribution by agency/department as of February 2017 as reported by Truven and FY17 premium levels.
Savings for active and pre-65 retiree populations only.
[1] Savings based on number of visits calculated using 7/1/2017 membership count; X-rays, ultrasounds and mammography are grouped under basic imaging, all other radiology services are grouped under high tech.
[2] Savings based on the number of unique members that had claims in these categories in the previous year.
[3] Preliminary design presented during 8/21 SEBC meeting; rounding may cause some numbers to vary slightly from original document. NOTE: Related to the Lab steerage for the Aetna population, Labcorp pricing is 2% higher in aggregate than Quest. Savings may change slightly (overstated) to the extent members utilize Labcorp over Quest facilities.

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Site-of-care steerage

Infusion therapy

Infusion therapy defined:

- Intravenous administration of certain medications that treat conditions such as autoimmune disorders, enzyme replacement and rare/esoteric diseases
- Administered under the supervision of a medical professional
- Several possible sites of care: outpatient hospital facility, infusion center, doctor's office, or patient's home

Advantages to administering outside of a hospital: *significantly reduced cost of drug administration, reduced risk of patient exposure to hospital-acquired illnesses, enhanced privacy and comfort, potentially reduced travel time and associated expenses*

Aetna capabilities

- Site-of-care steerage program is currently in place for the State
- Drugs are segmented into two categories: Mandatory and Voluntary (based on clinical rule)
- Requires member's doctor to request prior authorization for infusion therapy from Aetna
- Aetna reviews request for medical necessity and clinical appropriateness
- Aetna will reach out to doctor to suggest alternative site of care if appropriate

Highmark capabilities

- Site-of-care steerage program is available for self-funded plan sponsors
- Also managed by a prior authorization initiated by the member's doctor, and includes review for medical necessity and clinical appropriateness
- Authorization will be denied if medical documentation submitted by doctor is insufficient to justify requested site-of-care or use of infusion
- Includes appeal process to address denied requests for prior authorization

Estimated annual claim savings potential*: *FY18 – $500,000 (Aetna only); FY19 – $100,000 (Aetna only)*

*Note: Reflects savings potential for those steered in FY18 only; actual savings are not guaranteed and should not be relied upon for budgeting purposes.

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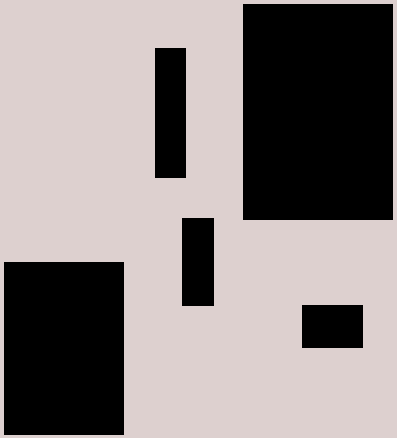
Centers of Excellence



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Centers of excellence

Member impact – illustrative scenario *(assuming COE differential adopted)*

PPO Plan – Knee Replacement Surgery	
Current Provision	Revised Provision for Ortho/Spine COEs (Illustrative)
▪ $100 per-day confinement copay (up to 2 days)	▪ $100 per-day confinement copay for COE-designated facility ▪ 10% coinsurance for non-COE-designated facility[1]

Scenario

- Member is covered by the Comprehensive PPO plan in EE Only coverage
- Member needs knee replacement surgery
- Primary care doctor recommends an orthopedic surgeon to perform the knee replacement
- Referral provided by primary care doctor is to a non-COE facility
- Example assumes $35,000 cost for surgery

Action

- Member calls health plan customer service to confirm whether surgeon and facility are in-network
- Member can also use their medical carrier's provider search tool to identify facilities within COE network
- Health plan customer service educates member on COE network benefits (both cost and quality)

Direction

Non COE Facility

- Member gets surgery at non-COE facility

Outcome[2]

Non COE Facility

- Member pays $3,500 in coinsurance[3]

Direction

COE Facility

- Member gets surgery at COE facility

Outcome[2]

COE Facility

- Member pays $200 copay
- Because COE is used, additional benefits (to the member and the GHIP) include:
  - ✓ Surgery and post-operative care may be delivered more efficiently
  - ✓ Lower risk of complications and readmissions
  - ✓ Lower cost over time without sacrificing quality of care

1. Member cost sharing for non-COE-designated facilities reflects the design provisions in "Year 1" of the 3-year phased in approach illustrated on the following pages.
2. Cost shown for illustrative purposes only and may vary based on provider and diagnosis.
3. Assumes member has not incurred any other claims YTD; member's coinsurance payment ($3,500) will count toward their out-of-pocket maximum ($4,500 for EE Only coverage in the Comprehensive PPO plan).

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Centers of excellence

Member impact – out-of-pocket costs for non-COE, in-network facilities

Scenario: Knee replacement surgery

	PPO / HMO		
	Hospital A	**Hospital B**	**Hospital C**
Estimated total cost[1] (negotiated allowed amount)	$38,800	$42,900	$37,000

Member cost to use a non-COE, in-network facility (assuming EE Only coverage)	**Hospital A**	**Hospital B**	**Hospital C**
Current plan design	$200	$200	$200
10% coinsurance	$3,880	$4,290	$3,700
20% coinsurance[2]	$4,500	$4,500	$4,500
25% coinsurance[2]	$4,500	$4,500	$4,500
$500 copay	$500	$500	$500
$750 copay	$750	$750	$750
$1,000 copay	$1,000	$1,000	$1,000

- Current plan design (PPO / HMO): $100 copay per day with max of $200 per admission
- Member out-of-pocket cost associated with using a COE facility would reflect the current plan design (no change in cost share)

[1] Estimated total cost reflects blend of costs provided by Highmark and Aetna procedure cost estimator tools. Value reflects cost associated with the episode of care associated with knee replacement surgery, including cost for the procedure/hospital admission, DME and physical therapy. **For simplicity, estimated total cost treated as facility/procedure cost.**
[2] Member cost is capped at the annual out-of-pocket (OOP) maximum; example assumes OOP maximum associated with Employee Only coverage.

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Centers of excellence

Potential phased-in approach – coinsurance option

PPO / HMO	Current Design[1]	Proposed Design – Coinsurance Option		
		Year 1	Year 2	Year 3
COE Facility In-network	$100 copay per day $200 copay max/admission	$100 copay per day $200 copay max/admission	$100 copay per day $200 copay max/admission	$100 copay per day $200 copay max/admission
Non-COE Facility In-network	$100 copay per day $200 copay max/admission	10% of negotiated allowed amount	20% of negotiated allowed amount	25% of negotiated allowed amount
Estimated annual claim savings[2] (Represents incremental savings each year)		**$2.2m (0.4% of claims)** **($1.4m General Fund)**	**$1.3m (0.2% of claims)** **($0.8m General Fund)**	**$0.7m (0.1% of claims)** **($0.5m General Fund)**

- This option reflects coinsurance provision for members utilizing non-COE facilities, with level of coinsurance increasing in Year 2 and Year 3; applicable to any procedures eligible for treatment at an orthopedic or spine COE
- Estimated savings includes steerage as a result of plan design as well as reduction in cost due to high quality of care delivered by COEs (resulting in lower rates for readmissions, infections, complications, etc.)
- Proposed changes to the plan design for the First State Basic and CDH Gold plans are included in the Appendix

Savings estimates provided by Aetna and Highmark. Savings for active and non-Medicare retirees only.
[1] Based on inpatient services only.
[2] Savings estimates exclude the impact of trend. Savings estimates include design changes for the First State Basic and CDH Gold plans; see Appendix for the proposed changes associated with those plans. Change in number of available COEs (introduction of new, or removal of COE facility) would impact estimated annual claim savings shown.

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Centers of excellence

Potential phased-in approach – copay option

PPO / HMO	Current Design[1]	Proposed Design – Copay Option		
		Year 1	Year 2	Year 3
COE Facility In-network	$100 copay per day $200 copay max/admission	$100 copay per day $200 copay max/admission	$100 copay per day $200 copay max/admission	$100 copay per day $200 copay max/admission
Non-COE Facility In-network	$100 copay per day $200 copay max/admission	$500 copay per admission	$750 copay per admission	$1,000 copay per admission
Estimated annual claim savings[2] (Represents incremental savings each year)		**$0.7m (0.1% of claims)** **($0.5m General Fund)**	**$0.5m (0.1% of claims)** **($0.3m General Fund)**	**$0.4m (0.1% of claims)** **($0.2m General Fund)**

- This option reflects higher copay provision for members utilizing non-COE facilities, with level of copay increasing in Year 2 and Year 3; applicable to any procedures eligible for treatment at an orthopedic or spine COE
- Estimated savings includes steerage as a result of plan design as well as reduction in cost due to high quality of care delivered by COEs (resulting in lower rates for readmissions, infections, complications, etc.)
- Proposed changes to the plan design for the First State Basic and CDH Gold plans are included in the Appendix

Savings estimates provided by Aetna and Highmark. Savings for active and non-Medicare retirees only.
[1] Based on inpatient services only.
[2] Savings estimates exclude the impact of trend. Savings estimates include design changes for the First State Basic and CDH Gold plans; see Appendix for the proposed changes associated with those plans. Change in number of available COEs (introduction of new, or removal of COE facility) would impact estimated annual claim savings shown.

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Centers of excellence

Recommended approach

- While the third party vendor marketplace continues to evolve, there exists an opportunity to move forward with a limited COE penetration with the GHIP's current vendor partners
  - The GHIP should continue to monitor the viability of the third-party COE vendor landscape, as future opportunities may exist
- The recommendation for FY19 would be to adopt the Orthopedic and Spine COEs for both Highmark and Aetna
  - Aetna's spine COE is embedded within their Orthopedic COE while Highmark Orthopedic and Spine COEs are separate
  - Offers a level of consistency in steerable conditions between both carriers
  - Drives members to the highest quality facilities, improving outcomes and reducing cost
  - Clear expectations will need to be set with both Aetna and Highmark to ensure protocol is in place to appropriately steer members and administer the program according to the GHIP's intention
- Design approach:
  - Similar to the steerage encouraged by the bariatric and transplant plan design, the recommendation is to utilize a consistent benefit differential, phased in over a 3-year period
    - COE Facility: Covered at current in-network benefit level *(no change from current design)*
    - Non COE Facility (in-network): Covered at varied copay/coinsurance level by Year 3 (after applicable out-of-pocket cost)
- Cost savings:
  - Moving forward with adopting the **orthopedic and spine COEs** for both Aetna and Highmark with either the copay/coinsurance design option that would yield up to $4.2m in savings ($2.7m savings to General Fund) over a 3-year period[1]

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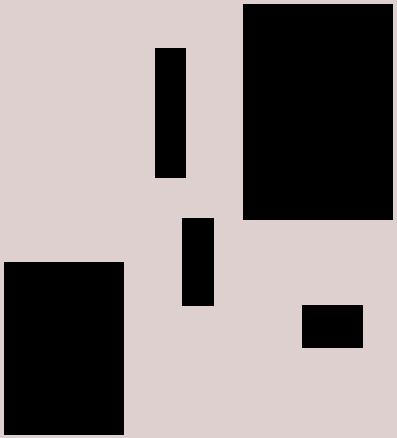
[1] Savings estimates exclude the impact of trend.

Active Enrollment



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Budget epilogue – Open Enrollment

- At the March 6, 2017 SEBC meeting, the Committee voted to modify the FY17 budget epilogue
  - Language was written over 10 years ago and had not been modified since
  - Epilogue was written after the PHRST eBenefits module was first implemented and employees who did not take action during open enrollment were defaulted to waived
- Modified FY18 language allows the SEBC to make the decision of whether to implement an active enrollment each year during budget renewal

FY17 budget epilogue language:

> Employees of the State of Delaware who are enrolled in a health insurance benefit plan must re-enroll in a plan of their choice during the open enrollment period as determined by the State Employee Benefits Committee. Should such employee(s) neglect to re-enroll in the allotted time, said employee(s) and any spouse or dependents shall be automatically re-enrolled in their previous plan as long as verification of employment is provided by the employee and the Office of Management and Budget.

Proposed revisions accepted by the Committee, 3/6/17:

> Support OMB and the General Assembly in making modifications to existing language to allow as determined to be necessary by the State Employee Benefits Committee, a requirement of all State of Delaware employees to actively participate in open enrollment by selecting a health plan or waiving coverage (specific language to be determined based on further research of system capabilities and required programming modifications)

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Section 23 FY 18 Budget epilogue – Open Enrollment

Employees of the State of Delaware who are enrolled in a health insurance benefit plan must actively participate in the open enrollment process each year by selecting a health plan or waiving coverage. Should such employee(s) neglect to enroll in a plan of their choice during the open enrollment period or waive coverage, said employee(s) and any spouse or dependents enrolled at the time will be enrolled into the default health plan(s) as determined by the State Employee Benefits Committee.

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Active enrollment

Considerations for the SEBC

Decision Point	Consideration	Potential Options
Groups subject to active enrollment	▪ Administrative limitations ▪ Availability of multiple plan choices – only one plan for Medicare retirees ▪ Level of potential disruption for specific groups	▪ Actives only? ▪ Other groups (leave of absence, retiree, Participating Groups)?
Required action	▪ Opportunity to collect additional information and/or promote use of health care consumerism tools	▪ Simply check off plan election ▪ Above plus update contact information ▪ Above plus use myBenefitsMentor tool
Default option	▪ Level of disruption and/or communication required ▪ Level of employee engagement ▪ Cost impact to State and employees/retiree if no action taken	▪ No coverage ▪ Current election if already covered under medical plan, or no coverage if new hire ▪ First State Basic plan ▪ HSA plan option (not for 7/1/18 – future state option if the State decides to implement an HSA plan)

Steps[1] that State of Delaware employees would follow at Open Enrollment

↓

Step 1: Confirm and/or provide contact information

↓

Step 2: Click on link to access the myBenefitsMentor tool

↓

Step 3: Click on link to make medical plan election

[1] Process would only apply to active State of Delaware employees (not Participating Groups or non-Medicare retirees). Process is subject to technical development and will need to address the fact that some employees (i.e., those who were recently hired before Open Enrollment) will not have access to myBenefitsMentor, as well as considerations for accommodating employees on leave of absence.

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Active enrollment

Illustrative impact: First State Basic plan default

Employee Impact
(if no action taken)

Current Election	Plan Design		Premium Contributions
	Potential increase in cost at point of care		*Reduction in monthly contribution*
PPO	• No deductible • Low copays for most services *Actuarial Value: 0.97*	**First State Basic** • $500/$1,000 deductible • 90% coinsurance *Actuarial Value: 0.91*	• Single: $105 to $28 *$77 less per month* • Family: $273 to $72 *$201 less per month*
HMO	• No deductible • Low copays for most services *Actuarial Value: 0.97*		• Single: $47 to $28 *$19 less per month* • Family: $124 to $72 *$52 less per month*
CDH	• $1,250/$1,500 HRA funding • $1,500/$3,000 deductible • 90% coinsurance *Actuarial Value: 0.96*		• Single: $36 to $28 *$8 less per month* • Family: $95 to $72 *$23 less per month*
State Impact	$5.7m reduction in GHIP gross cost if 10% EEs take no action and default to FBS		$4.1m reduction in employee contributions

For FY18 OE, 15% of employees utilized the myBenefitsMentor tool. Optimal plan recommendations across the overall active population: 57% CDH, 34% HMO, 9% FSB, <1% PPO

$1.6m reduction in State net cost ($1.2m State Share)[1]

Active enrollment will encourage more employees to review the options available and make an optimal plan choice for their situation, whether the default plan or something else, driving further savings for the State.

[1] Assumes 10% of PPO/HMO/CDH active plan enrollees take no action and default to the First State Basic plan; cost impact estimate based on FY18 rates and contributions, and August 2017 enrollment provided by Truven; State Share excludes participating groups.

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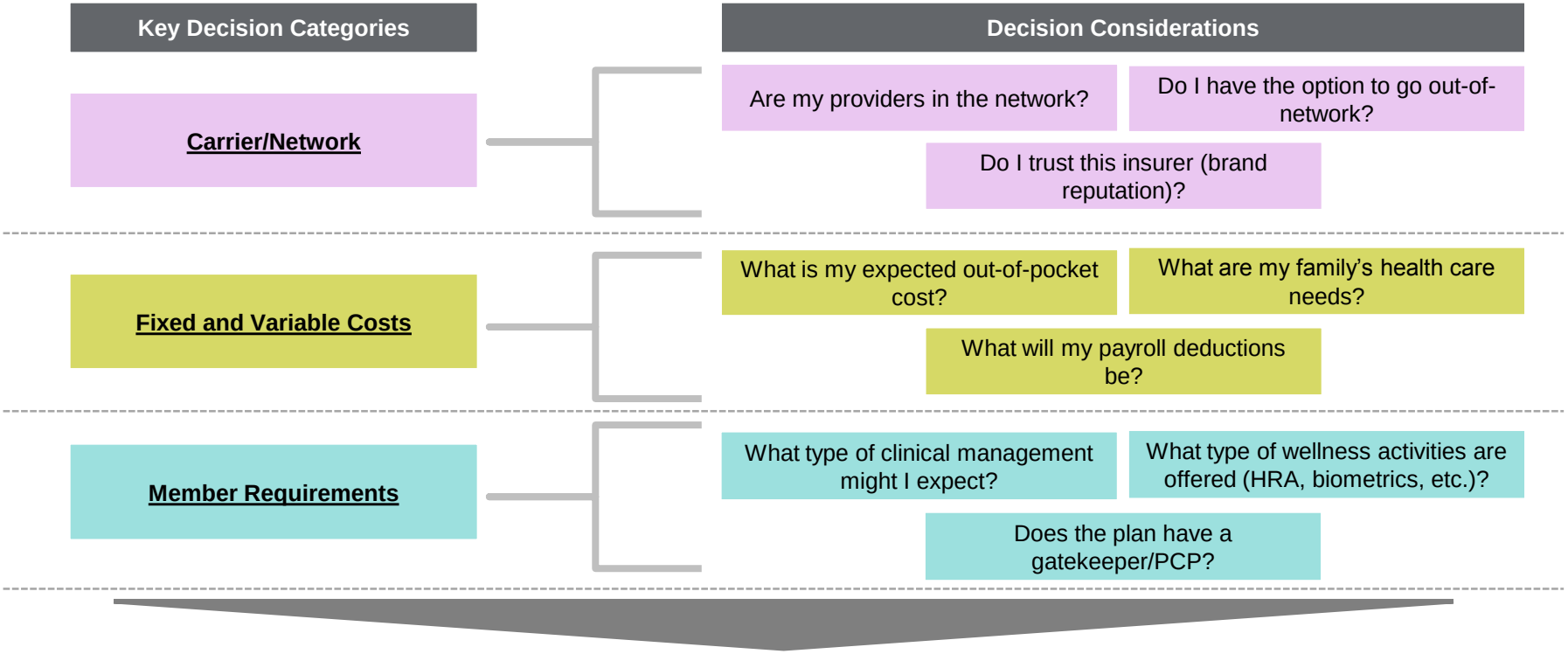
Active enrollment

Considerations for GHIP members

- At the point of enrollment, GHIP members have an opportunity to select a plan that best aligns with their current life situation



The open enrollment period is the time during which these key decision categories will be relayed to the member with an **Active Enrollment being an effective way of engaging members**

A robust decision support tool will guide members through a series of customized and personalized questions to help steer them to the best suited plan

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Next Steps

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Next steps

- Items to discuss at the December 11 SEBC meetings:
  - Review October Fund report
  - Review FY18 Q1 Financials
  - Vote on:
    - Spousal COB policy changes
    - Site-of-care steerage options
    - Centers of Excellence
    - Active Enrollment

- Items to discuss at upcoming SEBC meetings for FY19 and beyond:
  - Cost transparency tools
  - Employer-sponsored clinic follow up
  - Group Health Eligibility and Enrollment Rule changes
  - Possibility of modification to the plan year to align with calendar year (i.e., 7/1 to 1/1)

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Appendix

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Confines of the GHIP strategic development process

Tactics requiring legislative changes

Potential tactic to address strategy	Illustrative example(s)	Requires legislative change?
Traditional plan design changes	Increase deductible by $100	No
Non-traditional plan design changes	Implement reference-based pricing Add a third coverage tier for a narrow network	No
Adding a new medical plan	Adding CDHP/HSA or adding a PPO option that has a narrow network	No*
Removing a plan option specified by the Delaware Code	Removing the First State Basic plan	Yes**
Freezing enrollment in a medical plan	1. Freeze to new entrants 2. Freeze to new hires	Yes
Adding a vendor	Wellness vendor or engagement vendor	No
Adjustments in employee cost share	Increasing the payroll contribution for an employee from 12% to 15%	Yes
Adjustments in dependent cost share	Increasing the dependent cost sharing by 10%	Yes
Addition of surcharges	1. Add a tobacco and/or spousal surcharge 2. Wellness “dis-incentive” for non-participation	Yes
Addition of an incentive program	Paying an employee $100 to get their biometric screening from their PCP	No
Implement a medical or Rx utilization management program	1. Implement high cost radiology management program 2. Discontinue coverage of certain high cost specialty drugs and/or compound drugs	No

*Procurement would be involved in reviewing any amendments to vendor contracts for the new plan(s). Additionally, cost share would have to fit within one of the existing plans to avoid legislative change.
**May require legal input regarding Delaware Code.

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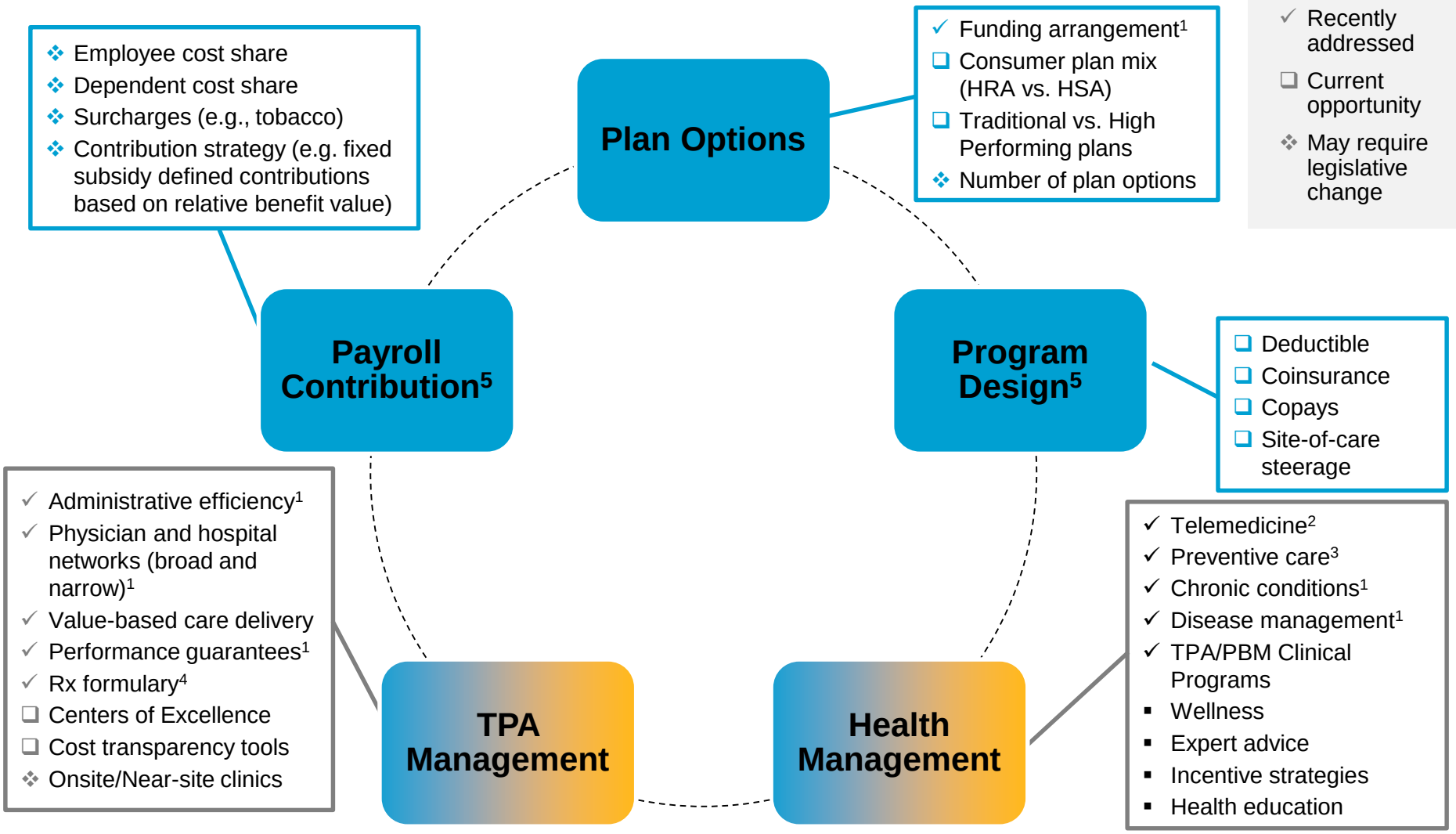
GHIP influencing levers

Tactics for affecting change and "shrink the pie"



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[1] Medical TPA RFP conducted in FY17.
[2] Implemented effective 7/1/16.
[3] Covered at 100% plan paid in network.
[4] Updated quarterly by Express Scripts.
[5] Tactics for affecting change in these categories may increase employee/pensioner share, with the goal of shrinking the pie overall

GHIP Strategic Framework Goals:

- ■ Addition of at least net 1 VBCD model by end of FY2018
- ○ Reduction of gross GHIP trend by 2% by end of FY2020
- ▲ Enrollment in a CDHP or value-based plan >25% by end of FY2020

Summary of savings opportunities

A sampling of ways to "shrink the pie"

Savings Opportunity	GHIP Goal	Member Impact		Savings Potential (General Fund) (12 months)
		Requires education or engagement?	Scope of potential impact	
Site-of-service steerage	○	Yes – Must know to use designated site of care	No negative impact to member cost if member utilizes designated site of care	$0.8m - $2.5m
Centers of Excellence	■ ○	Yes – Must know to use designated site of care	No negative impact to member cost if member utilizes designated site of care	$3.2m
Reference based pricing	○	Yes – Must be aware of "reference price" for particular service and associated provider pricing	Potential for members to be balance billed for costs in excess of "reference price"	Up to $1.9m
Cost transparency tools	○ ▲	Yes – Must be aware such tool exists in order to benefit from it. For the State, plan design changes would be a significant driver of member utilization	No negative impact to member cost if member doesn't use tool	TBD based on degree of member engagement / utilization
Tobacco surcharges[1]	○	Maybe – Depends on "default" option if member doesn't self-identify as tobacco user	Tobacco users would pay higher payroll contributions as a result of their tobacco use	Up to $5.3m
Implement HSA plan	○ ▲	Yes – Requires all employees to understand this plan option's impact on their total out-of-pocket costs as influencer of which option is elected. For enrollees, requires understanding of how the plan works (including the HSA)	For those enrolled in the plan, potential for higher member out-of-pocket cost sharing at point of care; and ability to leverage tax-advantaged account (HSA) to save and pay for medical expenses.	TBD based on enrollment and final plan design
Plan design changes for current plans	○	Yes – Employees need to be aware of plan design changes and how those would affect their out-of-pocket cost for coverage under each plan option	Potential for higher member out-of-pocket cost sharing at point of care	Up to $23.3m[2]
Active benefits enrollment	▲	Yes – Must complete enrollment process or risk being defaulted into alternative plan option	Would affect all benefits-eligible employees/retirees who do not take action during Open Enrollment	TBD based on default option

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[1] Will require legislative change in order to implement.
[2] Represents gross savings.

Aetna/Highmark site-of-care steerage

Estimated savings summary – Preliminary Design (Design 1)[1]

Type of service	Current (Aetna HMO/ Comprehensive PPO In-network)	Preliminary Proposed Design 1	Aetna HMO Annual Claim Savings[2]		Total Savings Opportunity	Highmark Comprehensive PPO (In-network design) Annual Claim Savings[2]		Total Savings Opportunity
			(%)	($)		(%)	($)	
Basic imaging services (e.g., X-rays, ultrasounds)	▪ Outpatient facility: $20 copay	▪ Outpatient facility, freestanding: $0 copay ▪ Outpatient facility, hospital-based: $35 copay	0.05%	$0.1m	**$0.5m** ($0.3m general fund)	0.10%	$0.4m	**$0.8m** ($0.5m general fund)
High tech imaging services (e.g., MRI, CT scans)	▪ Outpatient facility, freestanding: $0 copay ▪ Outpatient facility, hospital-based: $35 copay	▪ Outpatient facility, freestanding: $0 copay ▪ Outpatient facility, hospital-based: $50 copay	0.05%[3]	$0.1m		0.05%	$0.2m	
Outpatient lab services	▪ Any lab: $10 copay	▪ Preferred lab (Quest/ LabCorp): $10 copay ▪ All other labs: $20 copay	0.20%	$0.3m		0.05%	$0.2m	

Combined Aetna/Highmark Total Annual Savings Opportunity – Preliminary Design 1: $1.3m

- Savings estimates assume that these changes are applicable only to Aetna HMO plan and Highmark Comprehensive PPO plan in-network design provisions
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and hospital-based outpatient facilities to differentiate between basic imaging and high tech imaging

[1] Preliminary design presented during 8/21 SEBC meeting.
[2] Savings estimates based on assumed utilization; estimates provided on 9/6/2017. Savings for active and pre-65 retiree populations only.
[3] Aetna commented that high tech imaging services yield <0.1% claims savings. 0.05% savings assumed.

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Aetna/Highmark site-of-care steerage

Estimated savings summary – Design 2

Type of service	Current (Aetna HMO/ Comprehensive PPO In-network)	Proposed Design 2	Aetna HMO Annual Claim Savings[1]		Total Savings Opportunity	Highmark Comprehensive PPO (In-network design) Annual Claim Savings[1]		Total Savings Opportunity
			(%)	($)		(%)	($)	
Basic imaging services (e.g., X-rays, ultrasounds)	▪ Outpatient facility: $20 copay	▪ Outpatient facility, freestanding: $10 copay ▪ Outpatient facility, hospital-based: $45 copay	0.15%	$0.3m	**$0.7m** ($0.5m general fund)	0.24%	$0.9m	**$1.3m** ($0.8m general fund)
High tech imaging services (e.g., MRI, CT scans)	▪ Outpatient facility, freestanding: $0 copay ▪ Outpatient facility, hospital-based: $35 copay	▪ Outpatient facility, freestanding: $10 copay ▪ Outpatient facility, hospital-based: $60 copay	0.08%[2]	$0.1m		0.03%	$0.1m	
Outpatient lab services	▪ Any lab: $10 copay	▪ Preferred lab (Quest/ LabCorp): $10 copay ▪ All other labs: $25 copay	0.25%[3]	$0.3m		0.06%[3]	$0.3m	

Combined Aetna/Highmark Total Annual Savings Opportunity – Design 2: $2.0m

- Savings estimates assume that these changes are applicable only to Aetna HMO plan and Highmark Comprehensive PPO plan in-network design provisions
- While high tech imaging site-of-care steerage is already in place with the GHIP, the above proposal furthers the copay spread between freestanding and hospital-based outpatient facilities to differentiate between basic imaging and high tech imaging

[1] Savings estimates based on assumed utilization; estimates provided on 9/6/2017. Savings for active and pre-65 retiree populations only.
[2] Aetna commented that high tech imaging services yield <0.15% claims savings. 0.08% savings assumed.
[3] Lab savings estimated from initial projection provided by Aetna and Highmark.

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Aetna and Highmark COE criteria

- Aetna COE definition – facilities that have demonstrated high levels of quality and cost efficiency performing certain procedures
  - **Institutes of Quality** – Bariatric, Cardiac, Orthopedic (joint replacement and spinal surgery)
  - **Institutes of Excellence** – Transplants (organ and bone marrow), Infertility Treatment
- Highmark COE definition – facilities that deliver high-quality care and superior outcomes for high-risk, high-cost surgical procedures ("Blue Distinction Specialty Care" nationwide quality designation)
  - Specialty areas – Bariatric, Cancer (rare and complex), Cardiac, Maternity, Orthopedic – Knee & hip replacement, Orthopedic – Spinal surgery, Transplants
  - **Blue Distinction Centers (BDC)** – demonstrated quality care, treatment expertise and, overall, better patient results
  - **Blue Distinction Centers+ (BDC+)** – offer more affordable care in addition to having demonstrated quality care, treatment expertise, and, overall, better patient results

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Aetna COEs in Delaware and nearby states[1]

	Within Delaware	Within nearby states (up to 100 mile radius)
Cardiac	None in Delaware	**Maryland** Baltimore-area facilities – 5 Other Maryland facilities – 1 ▪ Including: Peninsula Regional Medical Center – Salisbury, MD **New Jersey** Northern-area facilities – 1 Other New Jersey facilities – 1 **Pennsylvania** Philadelphia/Southern NJ-area facilities – 1 Other Pennsylvania facilities – 5 **Washington, D.C.** D.C. and surrounding areas – 2
Orthopedic / Spine	**Christiana Care –** Wilmington, DE	**Maryland** Baltimore-area facilities – 9 Other Maryland facilities – 0 **New Jersey** Northern-area facilities – 0 Other New Jersey facilities – 0 **Pennsylvania** Philadelphia/Southern NJ-area facilities – 8 Other Pennsylvania facilities – 7 **Washington, D.C.** D.C. and surrounding areas – 4

1. Facilities that are designated as COEs for multiple clinical areas (i.e., cardiac and orthopedic/spine) are counted in each applicable clinical area above.

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Highmark COEs in Delaware and nearby states[1]

	Within Delaware	Within nearby states (up to 100 mile radius)
Cardiac	**Bayhealth Hospital** – Dover DE **Beebe Medical Center** – Lewes, DE **Christiana Care –** Newark, DE	**Maryland** Baltimore-area facilities – 1 Other Maryland facilities – 1 • Peninsula Regional Medical Center – Salisbury, MD **Pennsylvania** Philadelphia-area facilities – 7 Other PA facilities – 15 **Washington, D.C.** D.C. and surrounding area – 3
Orthopedic	None in Delaware	**Maryland** Baltimore-area facilities – 11 Other Maryland facilities – 7 • Including: Peninsula Regional Medical Center – Salisbury, MD **Pennsylvania** Philadelphia-area facilities – 13 (including 2 in Southern NJ) Other PA facilities – 17 **New Jersey** Other NJ facilities – 2 **Washington, D.C.** D.C. and surrounding area – 6
Spine	**Beebe Medical Center** – Lewes, DE **Christiana Care –** Newark, DE	**Maryland** Baltimore-area facilities – 8 Other Maryland facilities – 4 • Including: Peninsula Regional Medical Center – Salisbury, MD **Pennsylvania** Philadelphia-area facilities – 9 (including 1 in Southern NJ) Other PA facilities – 10 **Washington, D.C.** D.C. and surrounding area – 4

1. Facilities that are designated as COEs for multiple clinical areas (i.e., cardiac and orthopedic/spine) are counted in each applicable clinical area above.

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Centers of excellence

Comparison of carve-in and carve-out approaches

- While Highmark and Aetna both offer COEs for a wide variety of procedures, there exist several carve-out vendors that can administer a COE network
- Three leaders in this space include: BridgeHealth, Carrum Health and SurgeryPlus
  - BridgeHealth: Network not currently built in the DE (and surrounding) marketplace
  - Carrum Health: Network primarily located in western United States
  - Surgery Plus (Employer's Direct): Network not currently built in the DE (and surrounding) marketplace

Comparison of Carve-in and Carve-out COE Approaches

	Medical Carriers	Carve-Out Vendors
COE Capabilities	More established in the COE marketplace than carve-out vendors and offer a wider range of procedures. Generally, COE is not available by specific procedure, but only by group of procedure categories (i.e., cardiac)	Offer more flexibility and robust concierge coordination support
COE Network	Focus on facility COE designations, but these may differ from other provider designations such as Aetna Aexcel and Highmark True Performance	Approaches to network development vary; some are facility-based and others are provider/surgeon-based Would need to partner with medical TPAs to ensure that claims incurred with providers that meet quality and cost standards can be adjudicated at the in-network level, regardless of medical plan out-of-network status
Savings and ROI	Do not typically offer bundled pricing or ROI or savings transparency	Focus on bundled pricing / case rates. Some carve-out vendors have demonstrated greater willingness to tie savings and ROI to performance guarantees
Fees	Fee often embedded within core ASO fees, or nominal PEPM fee charged for steerage to COE network	Typically charge a fee (PEPM and/or a percentage of savings associated with the bundled case rates per surgery)

SEBC should continue to monitor the marketplace for developments and consideration of future vendor exploration

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Centers of excellence

Potential phased-in approach – CDH Gold and FSB design

CDH Gold / First State Basic	Current Design[1]	Proposed Design		
		Year 1	Year 2	Year 3
COE Facility In-network	90% after deductible	90% after deductible	90% after deductible	90% after deductible
Non-COE Facility In-network	90% after deductible	85% after deductible	80% after deductible	75% after deductible
Non-COE Facility Out-of-network	70% after deductible	65% after deductible	60% after deductible	55% after deductible

- Proposed design above would be applicable to any procedures eligible for treatment at an orthopedic or spine COE
- Savings associated with these design changes are included in the total estimated annual savings noted on the corresponding slides in the main part of this document

[1] Based on inpatient services.

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Centers of excellence

Historical view of COE utilization for GHIP members ***(Highmark)***[1]

Type of COE	Procedure	Total number of procedures (All facility types)	Total performed at COE facilities	Total performed at In-network non-COE facilities	Total performed at out-of-network facilities
Cardiac	Cardiac Valve	33	24	9	-
	Coronary Bypass	43	39	4	-
	Procedures with Coronary Artery Stent	100	87	13	-
	Extensive O.R. Procedure Unrelated to Principal Diagnosis	1	1	-	-
Orthopedic	Major Joint Procedures	23	9	14	-
	Revision of Hip or Knee Replacement	27	10	17	-
	Major Joint Replacement	632	137	495	-
Spine	Spine Surgery	11	8	3	-
	Spinal Fusion	143	111	32	-
	Multiple Significant Trauma	1	1	-	-
	Other Spinal Procedures	6	5	1	-

- Chart above reflects 24 months of GHIP experience for all cardiac, knee/hip and spinal procedures accessible through Highmark COEs
- All cardiac, orthopedic and spine procedures were performed at in-network COE and non-COE facilities
  - 58% of procedures were performed at non-COE facilities, driven by major joint replacement
  - The majority of major joint replacements were done in an in-network non-COE facility

[1] Claims period 08/01/2015 - 07/31/2017

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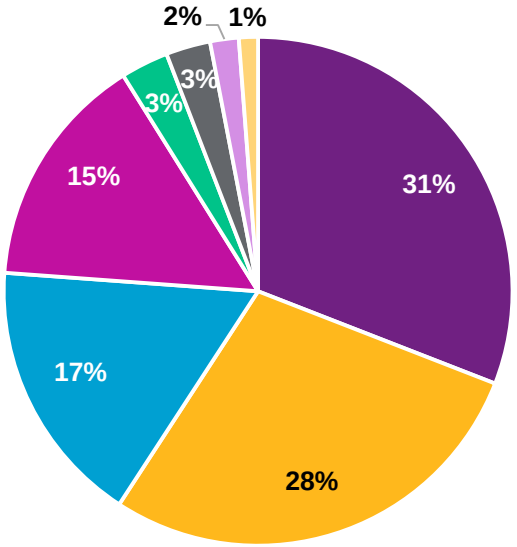
Historical view of COE utilization for GHIP members ***(Highmark)***

- 632 major joint replacements reported by Highmark from 8/1/2015 to 7/31/2017, 137 performed at COE facilities and 495 at in-network non-COE facilities
- The chart below details the procedures, categorized as major joint replacements, performed at in-network non-COE facilities (91% of total)
  - 59% (293) right or left knee joint replacements
  - 32% (158) right or left hip joint replacements



Orthopedic COE – Major Joint Replacement	
Procedures	**Total number of procedures performed at In-network non-COE facilities**
Right knee joint replacement	153
Left knee joint replacement	140
Right hip joint replacement	84
Left hip joint replacement	74
Total knee replacement	15
Other[1]	14
Percutaneous anesthetic into peripheral nerves and plexi	9
Total hip replacement	6
Total Major Joint Replacement Procedures	**495**

[1] "Other" category includes procedures performed less than three times during the 24-month period evaluated. Left hip joint, femoral surface replacement (3), left knee joint femoral surface replacement (3) therapeutic musculoskeletal exercise treatment (3); right knee joint tibial surface replacement (2), left knee joint tibial surface replacement (1), partial hip replacement (1) and right hip joint acetabular surface replacement (1)

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Historical view of COE utilization for GHIP members ***(Aetna)***[1]

Type of COE	Procedure	Total number of procedures (All facility types)	Total performed at COE facilities	Total performed at In-network non-COE facilities	Total performed at out-of-network facilities
Cardiac	Interventional[2]	2	-	2	-
	Rhythm	5	5	-	-
	Surgery	1	-	1	-
Orthopedic/ Spine	Total Joint Replacement	19	8	11	-
	Spine	17	15	2	-

- Chart above reflects 24 months of GHIP experience for all cardiac, knee/hip and spinal procedures accessible through Aetna COEs
- All cardiac, orthopedic and spine procedures were performed at in-network COE and non-COE facilities
  - All cardiac/rhythm procedures and most spine procedures were delivered at COE facilities
  - The majority of total joint replacements were done in an in-network non-COE facility

[1] Claim period 07/01/2014 - 06/30/2016
[2] Catheter based treatment of structural heart diseases

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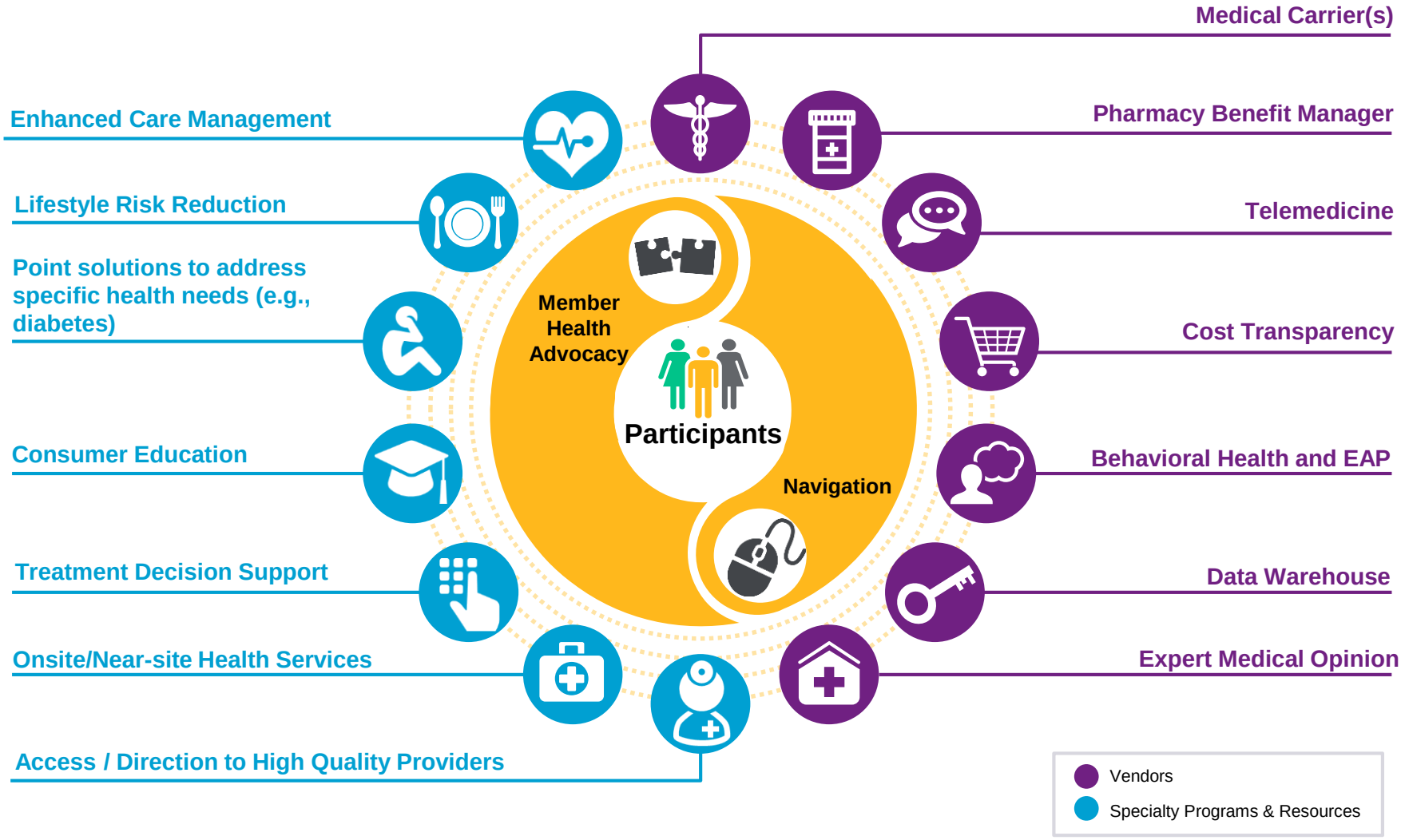
Strawman of health care program architecture designed to encourage consumer engagement



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